

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011804</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/02/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEARTH AT SYCAMORE VILLAGE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>611 W COUNTY LINE RD S</b> <b>FORT WAYNE, IN 46814</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00187472.</p> <p>Complaint IN00187472 - Unsubstantiated, due to lack of evidence.</p> <p>Survey Date: December 2, 2015</p> <p>Facility number: 011804 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 100 Total: 100</p> <p>Census payor type: Other: 100 Total: 100</p> <p>Sample: 3</p> <p>Hearth at Sycamore Village LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00187472.</p> <p>QR completed on December 3, 2015 by 17934.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE